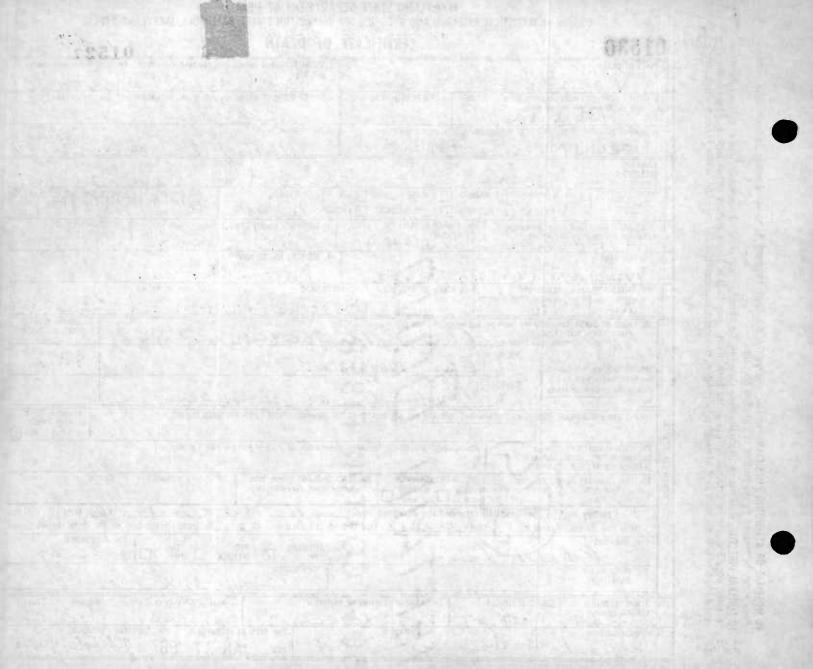
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01529 CERTIFICATE OF DEATH deoth he law requires that the death certificate be executed within 24 hours after death funeral 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) . PLACE OF DEATH o. COUNTY b. COUNTY and in ony event, within 72 hours after COSTER MARYLAND completely filled in by the c. CITY OR-JOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO remove corbon 3. NAME OF Middle 4. DATE First Lost Month Doy Year DECEASED DACE ER DEATH AN 19 6 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX DATE OF BIRTH AGE (In veors 6. COLOR OR RACE 7. MARRIED **NEVER MARRIEO** lost birthdoy) Months Doys Hours WIDOWED DIVORCED physicion and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME director, page 3 should be detached for use os the burial-tránsit permit. Then, should be filed with the State Dept. of Heolth prior to burial, cremotion, or remova CKL 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), ONSET ANO DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o signed by Page 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? CERTIFICATION NO YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20f. foctory, street, office bldg., etc.) Hour o.m. Not While 19 ot work 21. I certify that (1) (this haspital) attended the deceased from / - / -194 5, 10 P.M. from causes and on the date stated above. saw the deceased alive an /and that death accurred at/ 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) akING-It 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS**

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01530 CERTIFICATE OF DEATH within 24 hours after death. signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remave carban papers. Pages 1 and burial, crematian, or removal, and in any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY CEST MARYLAND b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn write RURAL and give neorest town) ERVIN e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give, street address) d. STREET ADDRESS ON A FARM? West St NO V 3. NAME OF Middle DATE Month First Last Day Year DECFASED OF DEATH 196 (Type or print) AGE (In years IF UNDER I YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH dost birthday) Months Days Hours X Dct. DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or fareign country) 90 during most of working life, even if retired) INDUSTRY COUNTRY? Bront UU: 5WIF 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME requires that the death cert 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or wnknown) (If yes give whr or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO 3 wefe Conditions, if ony, which gove (b) rise to immediate cause (a). DUE TO stating the underlying couse directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health prior to O FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year Hour o.m. foctory, street, affice bldg., etc.) Not While 19 at work ot wark 21. I certify that (1) (this hospital) attended the deceased fram and on 1962, to face 24, 1962, that (1) (we) last 3 shauld 24 1967, and that death accurred at 210 MM, from causes and on the dote stated above. sow the deceosed alive on, 22b. DATE SIGNED 22a. SIGNATURE ATTENDING STAFF 26-67 M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (State) REMOVAL (Specify) OP 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 01528 and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY by the f Pages 1 urs after Worcester Maryland MARYLAND Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b bon papers. Pag within 72 hours Pocomoke City E. years Pocomoke City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled a. IS RESIDENCE ON A FARM? d. STREET ADDRESS Clarke Avenue Clarke ND 3 YES Avenue within and completely remove carbon NAME DE First Middle Last 4. DATE Month Day Year DECEASED event, JOSEPH (Type or print) HARLAN HEN DERSON DEATH January 19 67 6. COLDR OR RACE 7. MARRIED X NEVER MARRIED 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | any Days Hours Male White WIDOWED DIVORCED Nov. 21,1906 60 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY FOO Q = 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician and eas Somerset County. COUNTRY? Mechanical Engineer Processing U.S.A. Maryland Molner's Maiden NAME certificate 13. FATHER'S NAME attending ph remova Austin Charles Henderson Sallie Ruark 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. 16. SDCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) No 213-05-5956 Mrs Irene Henderson. Pocomoke City, Md. CAUSE DF DEATH [Enter only one cause per lina for (a), (b), and (c).] INTERVAL BETWEEN signed by urial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE Jins been s. the burial. burial, c Conditions, If any, which gave rise to immediate as the prior to DUE TO causa (a), stating underlying causa last. has TIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? certificate ND C 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING OF CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this cerum detached for DESCRIBE HOW INJURY OCCURRED. (Enter natura of Injury In Part I or Part II pl Kem 18.) CER CAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Homa, farm, I 20f. (City or town) (County) (State) be de State factory, street, office bldg., etc.) Hour a.m. After Id be d Not While at work p.m 19 at work retained 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the and that death occurred at 715 saw the deceased alive on. PM, from the causes and on the date stated above. 22a. SIGNATURE De pe page ATTENDING STAFF DIRECTOR PHYS. FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) 302 Market. Pocomoke City.Md Trader, M.D. Charles W. 23c. NAME OF CEMETERY OR CREMATON BURIAL, CREMATION. 23b. DATE THEREOF 23d. LDCATION (City, town or county) (State) 0 REMOVAL (Specify) -11-1967 Burial First Baptist Pocomoke City. Maryland FUNERAL DIRECTOR ADDRESS 25b. REGISTRAR'S SIGNATURE lianles Pocomoke City, Md. VR A15 (4) 20M 1/65 Watson H

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TO HOSPITAL	Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 shoul should be filed with the	22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD 22d. ADDRESS P. O. Box 126, Berlin, M	4d. 21811
HO	Page 4 FUNER director,	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY 23d. LOCATION (City, town or count	1
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01530 CERTIFICATE OF DEATH funeral 1. PLACE OF OEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE after Worcester Maryland Worcester the MARYLAND by the Pages CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b papers. rehours Rural-Pocomoke City Rural-Pocomoke City Life .= filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE within 72 ON A FARM? R.F.D. R.F.D. YES X NO within letely carbon NAME OF First Middle Last OATE Month Day Year **OECEASEO** 30 67 event. EDWARD MASON (Type or print) **OEATH** January 19 AGE (In years | IF UNOER 1 YEAR | IF UNOER 24 HRS. | Iast birthday) | Months | Days | Hours | Min. executed 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIEO any White Male 1896 WIDOWED DIVORCED Oct physician and physician please representation in please representation in physician ph 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) II. BIRTHPLACE (County & State, or foreign country)
Worcester County, 12. CITIZEN OF WHAT .5 10b. KIND OF BUSINESS OR INDUSTRY COUNTRY? certificate be Farming Farmer U.S.A Maryland removal. 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending ph ermit. Then Julius Mason Arenthia Disharoon 15. WAS DECEASED EVER IN U.S. ARMEO FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address been signed by the atten the burial-transit permit. or to burial, cremation, or death Yes W.W. 1 6-18-2073 Mrs Lela Mason, City, Md. Pocomoke 18. CAUSE OF OEATH [Enter only one caus fine for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, if any, which (b) gave rise to immediate OUF TO (a), stating the as the underlying cause last is certificate has (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use PERFORMED? YES NO X 20a. ACCIOENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) of detached MEDICAL 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm. (County) (State) 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While While After be retained by at work at work should DIRECTOR: Jage 3 should lied with the 21. I certify that (I) (this hospital) attended the deceased from 196 f. from the causes and on the date stated above. saw the deceased alive on and that death occurred at DATE SIGNED 22a. SIGNATUR 22b. ATTENOING PHYS. STAFF PHYS. M.D. DIRECTOR Page 4 may pa FUNERAL 22d. ADDRESS PHYSICIAN'S director, p should be 1 NAME (Type) Horsey, Virginia Donald etcher 23c. NAME OF CEMETERY PROCREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, DATE THEREOF 23h. REMOVAL (Specify) 9 First Baptist Pocomoke City, Maryland Burial 2-2-1967 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR I FUNERAL DIRECTOR ADDRESS 25a. Pocomoke City, Md. VR A15 (4) DATE 15M 4-64 ber watson

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01534 CERTIFICATE OF DEATH funeral and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY 24 hours after Worcester Maryland Worcester MARYLAND Pages b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) à Whalevville Whaleyville Ξ app. 50 yrs Rural ve carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled e. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO etely death certificate be executed within 3. NAME OF DECEASED First Middle Last DATE Month Day Year F. McCabe 1967 comple Harry 30 (Type or print) DEATH Jan. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 7. MARRIED NEVER MARRIED pue white 3. Aug. male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A. farmer farming Sussex County. Dela. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending pharmit. Then гетоуа Lemuel McCabe Lillian Evans d by the attend transit permit. cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) (If yes give war or dates of service) Whalevville, Md. Mary E. McCabe -16-8CAUSE OF DEATH [Enter only one cause per line for (a), INTERVAL BETWEEN requires that the -transit ONSET AND DEATH I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed burial-tr burial, DUE TO Cenditions, If any, which gave rise to Immediate r the DUE TO cause (a), stating the prior t underlying cause last. (c) SS CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY Health PERFORMED . certificate YES NO T 0 this cerum detached fo 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) be detached State Dept. MEDICAL (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) factory, street, office bldg., etc.) Hour a.m. Not While at work at work p.m. 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lied with the and that death occurred all 30 M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SICNED 22a. PHYS. DIRECTOR M.D. TO FUNERAL I PHYSICAN'S HOSPITAL 22c. 22d. ADDRESS BURIAL, CREMATION. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (State) (Specify) Ebenezer Cem. Worcester, Md. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SICNATURE Dela. DATE 20M 1/65

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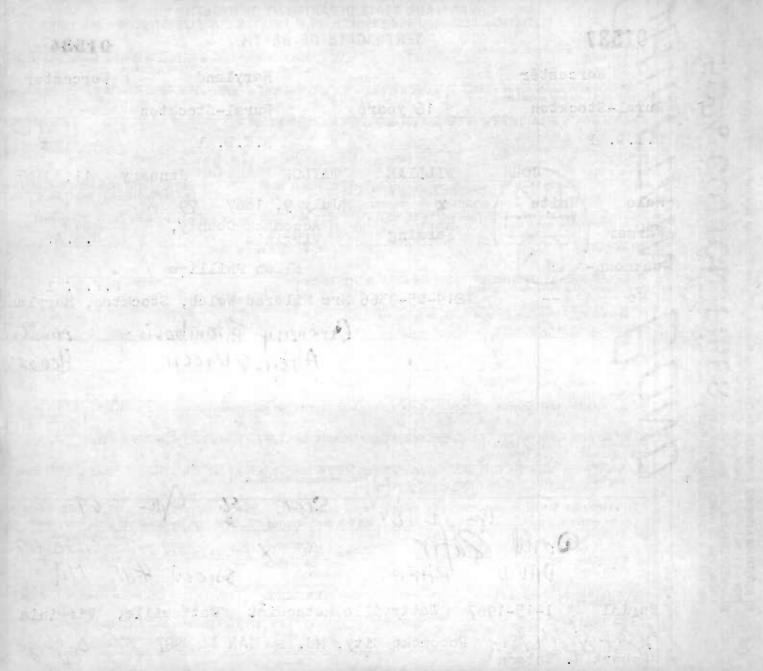
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 and 2 death. 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY after by the figure 1 Pages 1 irs after Worcester Maryland MARYLAND Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b oon papers. Pag within 72 hours hours Bishopville Rural Life Bishopville Md. Rural = d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO D YES within completely carbon NAME DE First Middle DATE Last 4. Month Day Year DECEASED event, Purnell Albert Z. (Type or print) January 6 1967 DEATH executed 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. remove 7. MARRIED NEVER MARRIED colored 26,1907 Male WIDOWED X Apr. DIVORCED 10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) INDUSTRY Ξ physician n please r 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Chicken Plant Laborer Worcester Co.Md. certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phermit. Then removal John J. Purnell Annie Kate Purnell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. transit permit. Address death (Yes, no, or unkown) (If yes give war or dates of service) Bishopville.Md. Margie Pernell the burial, crams 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). the hospital or attending physician. Myocardial Infarction Immediate been signed DUE TO Hypertensive Cardio-vascular Disease Cenditions, If any, which gave rise to immediate the r DUE TO cause (a), stating the underlying cause last. has CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health certificate PERFORMED? Arthritis NO -YES [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) detached f te Dept. of this 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. After Id be d Not While at work p.m. 19 at work 21. I certify that (I) MANNE MODEL attended the deceased from DIRECTOR: age 3 should led with the AM, from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22a. SIGNATURE DATE SIGNED ATTENDING page 1/7/67 M.D. DIRECTOR 4 may O HOSPITAL O FUNERAL director, p 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Md., Jr. Ivory Sully. MD. Berlin. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Jan. 9. 1967 Showell Cemetery Md. Burial Showell FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. Selbyville, Del. VR A15 (4) 20M 1/65

a fra nets forms Later the section of De marine and Alberts and State and to the test as year to Parametrale and a free and a first that the same The same of the sa from U duely of Lower Company of Powers . Suff Bring of the fiel I to the all the eliteration

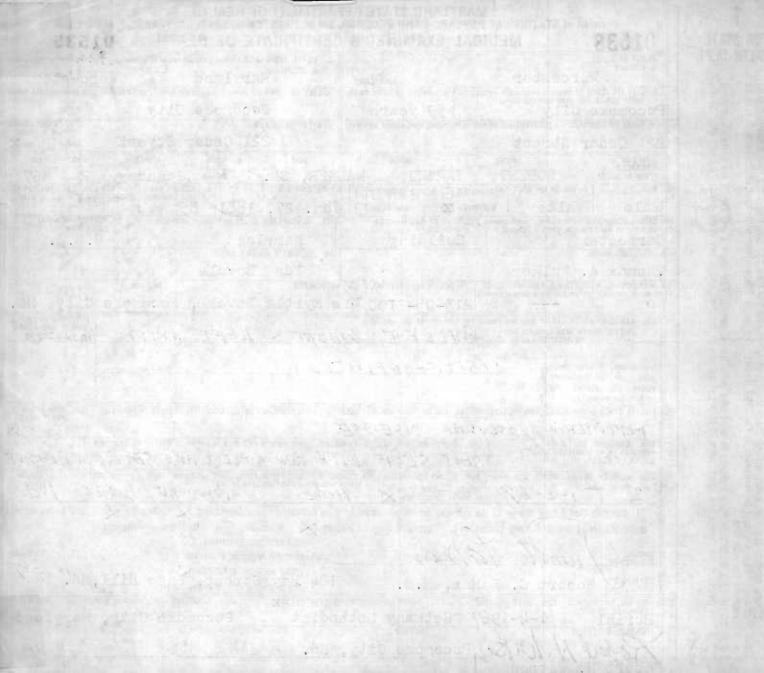
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01536 CERTIFICATE OF DEATH and 2 be executed within 24 hours after death campletely filled in by the funeral tove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence o. COUNTY o. STATE Maryland b. COUNTY Orcester Worcester MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill Snow d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Shipyard Alley Shipvard Allev YES NO T 3. NAME OF First Middle Lost 4. DATE Doy Year DECEASED 10 1967 DOROTHY STANLEY January (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH remove lost birthdoy Months Hours Dovs WIDOWED DIVORCED Female Negro 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) ease during most of working life, even if retired) **INDUSTRY** COUNTRY? Molan law requires that the death certificate Housekeeper Virginia Home Own 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remaya Unknown Garland Stanley 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service James Mears. Snow Hill. Md. None 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO as the stoting the underlying couse has been lost. 19. WAS AUTOPSY PERFORMED? DISEASE CONDITION GIVEN IN PART 1(o) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TO FUNERAL DIRECTOR: After this certificate be retained by the haspital ar for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18. 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 19.68, to , 19 627 that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from. 1967, and that death occurred at M, fram causes and on the dote stoted obave. saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Snow Hill. Md directar, 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. (County) (Stote) REMOVAL (Specify)
Burial Snow Hill, Md. Jan Zion Bantist 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24 SHINERAL DIRECTOR VR A15 (4) 20 M 1/66 Mary's notate JA Snow Hill.

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1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE	1 MADVIAND
h 2ª in		01537 CERTIFICATE OF DEATH	01534
24 hours after death. filled in by the funeral apers. Pages 1- and 2 n 72 hours after death.		Description of Death a. COUNTY Worcester Marylano 2. USUAL RESIDENCE (Where deceased lived, If institute a. STATE Maryland b. COUNTY MARYLANO	tion: Residence before admission) Worcester
ours affin by the Pages		b. CITY OR TOWN (if outside corporate limits, write Formula Stockton) C. CITY OR TOWN (if outside corporate limits, write Formula Stockton) C. CITY OR TOWN (if outside corporate limits, write Formula Stockton) C. CITY OR TOWN (if outside corporate limits, write Formula Stockton)	URAL end give nearest town)
filled papers nin 72 h	10	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) R.F.D. 1 R.F.D. 1	e. IS RESIDENCE ON A FARM? YES X NO
withir upletely carbon nt, witl	3	NAME OF First Middle Last 4. OATE Month OF OF OF OF OF OTHER DECEASED (Type or print) JOHN WILLIAM TAYLOR OF OF OTHER DEATH January	0ay Year 11, 1967
executed within and completely remove carbon prans any event, within	1	6. COLOR OR RACE 7. MARRIED NEVER MARRIEO 8. OATE OF BIRTH 9. AGE (In years FU last birthday) Mor	NOER 1 YEAR IF UNDER 24 HRS.
e death certificate be executed within 24 hours after the attending physician and completely filled in by the toperation. Then please remove carbon papers. Pages autob. or removal, and in any event, within 72 hours after	3	Oa. USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired) Linguistry. Lingu	12. CITIZEN OF WHAT COUNTRY? U.S.A.
rtificating phy Then p	-	unknown- 14. MOTHER'S MAIDEN NAME Ellen Phillips	
attend)		R.F.D. 1 ton, Maryland
PHYSICIAN: The law requires that the death certificate be the hospital or attending physician. This certificate has been signed by the attending physician detached for use as the burial-transit permit. Then please e Dept. of Health prior to burial, cremation, or removal, and in		18. CAUSE OF OEATH (Enter only one cause per line for (a), (b), end (c). I PART I. OEATH WAS CAUSEO BY: IMMEDIATE CAUSE (a) IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND OFATH
equires ting physice speed signification signification in the purial to burial to burial to burial signification in the signification i		Conditions, If eny, which gave rise to immediate cause (a), stating the DUE TO OUE TO Attended Science Scien	Years
he law r r attend te has t use as t	2 ATION	underlying cause last. (c)	PERFORMEO?
CIAN: To Spital of Certification for the forethe for the forethe for the forethe foret	3	20a. ACCIOENT WAS UNDERLYING 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Pert II of ite of Contributing Cause of OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	YES NO 18.)
TO HOSPITAL OR ATTENDING PHYSICIAN Page 4 may be retained by the hospit of FUNERAL DIRECTOR: After this certificator, page 3 should be detached should be filed with the State Dept. of	Menical		(County) (State)
OR ATTENDING be retained by JIRECTOR: After ge 3 should be ed with the Stat	2		19 67 that (I) (we) last
OR AT y be ref DIRECT			b. OATE SICNEO 1-13-67
TO HOSPITAL OR Page 4 may be TO FUNERAL DIRE director, page should be filed by	1	22c. PHYSICIAN'S NAME (Type) DAVID RAPAT 22d. AGORÉSS SNOW HUI	' Hd.
Pag TO Fi		3a. BURIAL CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY ORXINAX 23d. LOCATION (City, town Burial 1967 Wattsville Methodist Wattsville	Virginia_
VR AI5 (4) 20M 1/65		Pobert N. We San Pocomoke City, Md. DATE JAN 16 1967 gc	harles Judge
		Robert H. Watson	UU



2 1 M	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	01538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01535
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
	Worcester Maryland Maryland Worcester
sary, leral / be nent nent	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 23/
fur may	Pocomoke City 23./
the the	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
letay is necessary, and 3 to the funeral Page 5 may be State Department hours after death.	221 Cedar Street YES NO NO
S. S. P. Po	3. NAME OF First Middle Last 4. DATE Month Day Year OF
PM3.	(Type or print) ROBERT LUTHER WALKER, SR. DEATH January 2 1967
s 1, 2 rm P rm P with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS.
ti ge at	Male White WIDOWED Jan. 27, 1881 85 yrs. William Willi
with with	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN DF WHAT COUNTRY?
s after 8. Girlong long any e	Carpenter Building Maryland U.S.A.
n 18. (e along pages in any	13. FATHER'S NAME
24 hou lem Office File p	Thomas A. Walker Ida Bowdle
in 124	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address No 213-05-2100 Mrs Myrtle Revell. Pocomoke City. Md.
pencil in miner's 0 permit. I	
AL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be rifles. Tools: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department designated agent, prior to burial, cremation, or removal, and in any elant, within 72 hours after death.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: PART I. DEATH WAS CAUSED BY:
uld be executed d "pending" in ef Medical Exar a burial-transit cremation, or	PART I. DEATH WAS CAUSED BY: A THE MINNTES MINNTES
exec ding ical ical	Conditions, If any, which \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
ben Med uria	gave rise to immediate (0)
a b	cause (a), stating the DUE TO underlying cause last, (c)
sho Ch as uria	
ficate sho the wor to the Chi used as to burial	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PEW PILEMAN UNSCRIBED DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. CAUSE OF DEATH. SHOT SELET WITH OWN RIFLE WITHE SEATED ON PROSIDE
ng dito	20a. EXTERNAL CAUSE WAS PRIMARY NO OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) CAUSE OF DEATH. CHOT SI-LE WITH OWN RIFLE WHILE SEATED ON BEOSIDE
vriti vriti uld	CAUSE OF DEATH. SHOT SELF WITH OWN RIFLE WHILE SEATED ON BEOSIDE
R: This certificate, writing forwarded to 3 should be agent, prior	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
C age 3	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) Pocumokis Work Adverse Work at work a
AL EXAMINEE the certifice the should be in files. CTOR: Page designated	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and In my opinion
EXA Shoul files.	death resulted from: Natural causes, Accident , Suicide , Homicide , Undetermined manner
th th s de s de	CHIEF MEDICAL EXAMINER
MEDICA xecute t Page 4 for your	SIGNATURE ACTUAL M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
TY MEDIC execute r. Page 4 d for you RAL DIRE	EXAMINER'S Robert C. LaMar, M.D. 104 Bay Street, Snow Hill, Md. 2-67
DEPUTY MEDICAL EXA lease execute the corrector. Page 4 shouls stained for your files. FUNERAL DIRECTOR: f Health or its design	
TO DEPUTY please et director. retained TO FUNERA of Health	PEMOVAL (Spacify)
T T	Burial 1-4-1967 Bethany Methodist Pocomoke City, Maryland 24 FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME	Robert H. Watsan Pocomoke City, Md. DATE JAN 6 1967 Icharley Judge
35DD 4-64	Robert H. Watson



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01539 within 24 hours after death and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) the funeral PLACE OF DEATH a. COUNTY Worcester b. COUNTY a. STATE MARYLAND hours after b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b autside corparate limits, write RURAL and give nearest tawn) write PURAL and give negrest town) campletely filled in by IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS signed by the attending physician and campletely filled in burial-transit permit. Then please remave carban papers burial, crematian, or removal, and in any event, within 72 NO / YES 3. NAME OF 4. DATE Day Year DECEASED 0F erman 6 001 19 DEATH (Type or print) certificate be executed AGE (In years IF UNDER 1 YEAR IF UNOER 24 HRS S. SEX 6. COLOR OR RACE DATE OF BIRTH last birthday) Manths Days Haurs WIDOWED DIVORCEO 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most af working life, (ven if retired) INDUSTRY I din COUNTRY ? 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME E112312 oren 20 INFORMAN) 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. requires that the death (Yes, na, ar unk nawn) (If yes give war ar dates af service) -05-89 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY hronic IMMEDIATE CAUSE (a) **OUE TO** Canditians, if any, which gave rise to immediate cause (a), DUE TO tar use as the t Health priar ta b stating the underlying cause be retained by the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? rascular sease NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20a. ACCIDENT WAS UNDERLYING detached for the Dept. af I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. (State) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) Haur a.m. Nat While factory, street, affice bldg., etc.) 19 ot wark at wark director, page 3 shauld be should be filed with the Stat 21. I certify that (1) (this hespital) attended the deceased from. that (1) (we) last M, from couses and on the date stated above and that death occurred at saw the deceased alive an, 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. **OIRECTOR** PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State 23a. BURIAL, CREMATION, 23b. DATE THEREOF. (County) POMOVAL (Specify) Berlin Work d Sunset Memorial 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR AODRESS 24. FUNERAL DIRECTOR VR A15 (4)